ADOPTION ASSISTANCE CHANGES AND REQUESTS

Use of form: Completion of this form is voluntary and meets the requirements of Wisconsin Administrative Code HFS 50.06(2). Personally identifiable information on this form is used to verify eligibility for Adoption Assistance benefits and will be used only for that purpose.

Instructions: If reporting an address change, list the names of all your children under Section I. If you need additional space, use Section V. Report other changes using one form per child. Additional forms may be obtained at www.dhfs.state.wi.us/Forms/FormListAD.htm or call toll free (866) 666-5532.

I. CHILD AND PARENT INFORMATION

Name - Child (Last, First, MI)	Birthdate - Child (mm/dd/yyyy)	Social Security Number
Name - Mother (Last, First, MI)	Telephone Number - Work ( )	Telephone Number - Home ( )
Name - Father (Last, First, MI)	Telephone Number - Work ( )	Telephone Number - Home ( )

II. CHANGE IN PARENT'S ADDRESS

Old Mailing Address (Street, City, State, Zip Code)

New Mailing Address (Street, City, State, Zip Code)

Date New Address Effective (mm/dd/yyyy)

New Telephone Number - Home ( )

FOR OFFICE USE ONLY

- ☐ DC = _____
- ☐ Notified DC
- ☐ Requested DC change
- ☐ Verified completion

Note: If your residential address is different from your mailing address, provide it in Section V.

III. CHANGE IN CHILD'S PLACEMENT

☐ My child is no longer living with me. Date child left home: _____ (mm/dd/yyyy)

Child's Current Living Arrangement (Check one)

☐ Runaway ☐ With relative(s) ☐ Living independently ☐ Foster home ☐ Residential Care Center

☐ Other - Specify: _____

Child's current address: _____ (Street, City, State, Zip Code)

☐ I do not have monthly expenses for the child named in Section I. I understand that the Adoption Assistance benefits for this child will end. If I begin supporting my child again, I will notify the division.

☐ I have the following monthly expenses for the child named in Section I:

Expense Type	**Expense Amount**
_____	$ _____
_____	$ _____
_____	$ _____

IV. OTHER CHANGES AND REQUESTS

Check all that apply for the child named in Section I.

☐ My child died on _____ . (mm/dd/yyyy)

☐ My parental rights were terminated on _____ . (mm/dd/yyyy)

☐ My child has a new guardian, _____ , effective _____ . Name - New Guardian (mm/dd/yyyy)

☐ My child graduated from _____ on _____ . Name - High School (mm/dd/yyyy)

☐ My child entered the military on _____ . (mm/dd/yyyy)

☐ My child was married on _____ . (mm/dd/yyyy)

OVER

IV. OTHER CHANGES AND REQUESTS (Continued)

☐ I am requesting a replacement Adoption Assistance check for the month / year: ____/____ .
My check was: ☐ Not received ☐ Lost ☐ Stolen ☐ Other - Specify: _____
If I find the original check I will return it to the address on page 2 of this form and I will not cash it.

☐ The payee of the Adoption Assistance check should be changed to _____ .
(If removing a name, both parents must sign this form in Section VI or attach a copy of the court order.)
(If changing due to death, attach a copy of the death certificate.)

☐ I am requesting a new Forward / Medicaid card for this child because the card:
☐ Was lost / stolen / damaged ☐ Was never received ☐ Needs ID changed to SSN
☐ Needs middle initial corrected ☐ Shows birth name ☐ Other - Specify: _____

☐ My previous health insurance policy was cancelled on _____ .
(mm/dd/yyyy)

☐ I have a new health insurance policy (other than the Forward / Medicaid card).
☐ This child is covered by the new policy. Complete the information below.

Name - Policyholder (Adoptive Parent)	Name - Insurance Company
Policy Number	Group Name and Number
Date - Coverage Started (mm/dd/yyyy)	Date - Coverage Ended (mm/dd/yyyy)

☐ I am requesting a list of post-adoption resource centers. (This information is also available on the Internet at www.dhfs.state.wi.us/children/adoption/adoptpst.htm.)

☐ I am requesting information regarding a possible amendment to increase my Adoption Assistance.

V. ADDITIONAL INFORMATION

VI. AUTHORIZATION

I hereby certify that the information I have provided is true to the best of my knowledge.

Name - Person Completing Form (Print name)	Relationship to Child	Date - Form Completed
SIGNATURE - Person Completing Form		Date - Form Signed

If you have questions, contact the Bureau of Programs and Policies at (866) 666-5532.

Return completed form to: Adoption Assistance Program
Department of Health and Family Services
Division of Children and Family Services
Bureau of Programs and Policies
P.O. Box 8916
Madison, WI 53708-8916

This form can be faxed to (608) 264-6750